(a) The desk-reviewed, actual, allowable per diem indirect care costs from the three-month cost report multiplied by an inflation rate plus the fiscal year efficiency incentive for the applicable bed-size group based upon the number of medicaid-certified beds of the ICF-MR as determined under rule 5101:3-3-83 of the Administrative Code. The inflation rate shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid by a prorated portion of the eighteen-month inflation rate determined under rule 5101:3-3-83 of the Administrative Code for that fiscal year; or

(b) The maximum rate for the ICF-MR bed-size group as determined under rule 5101:3-3-83 of the Administrative Code for the fiscal year in which the rate will be paid.

(d) The rate for capital costs shall be determined as follows:

(i) The initial rate shall be determined under paragraphs (A)(1) to (A)(3) and paragraphs (B)(1) to (B)(3) of rule 5101:3-3-84 of the Administrative Code using the greater of an imputed occupancy rate of eighty per cent or the estimated inpatient days and the costs reported in a three-month projected cost report beginning the first day of medicaid participation subject to the limitation under rule 5101:3-3-84 of the Administrative Code for the fiscal year in which the rate will be paid. The three-month projected cost report shall include schedules A, A-1, D and D-1 of the JFS 02524 medicaid cost report for ICF's-MR and nursing facilities (NFs). ODJFS shall begin to pay the rates based on the three-month projected cost report one month after the first day of the month after the department receives the report. In the event the ICF-MR does not submit a three-month projected cost report, the ICF-MR shall be assigned the median capital rate of all ICFs-MR as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-84 of the Administrative Code.

(ii) After the ICF-MR files its three-month cost report under rule 5101:3-3-20 of the Administrative Code, the rate shall be the lesser of the desk-reviewed actual, allowable, per diem capital costs from the three-month cost report or the limitation determined under rule 5101:3-3-84 of the Administrative Code

for the fiscal year in which the rate will be paid.

(e) Rates based upon data from the three-month cost report filed under rule 5101:3-3-20 of the Administrative Code, as calculated under paragraphs (A)(1)(a) to (A)(1)(d) of this rule shall be effective starting the first day of the calendar quarter that begins more than ninety days after ODJFS receives the cost report. If the three-month cost report is filed after the ninety day due date and this report results in a lower rate, the rate shall be effective on the first day of the calendar quarter following one-hundred and eighty days after the end of the cost reporting period.

(2) After the end of the fiscal year in which the ICF-MR began participation in the medical assistance program, the rates for the second fiscal year and subsequent fiscal years shall be set using the ICF-MR's cost report filed under rule 5101:3-3-20 of the Administrative Code for the full calendar year preceding the fiscal year in which the rate will be paid and the provisions of rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83, and 5101:3-3-84 of the Administrative Code. If the ICF-MR did not file a cost report for the calendar year preceding the fiscal year, ODJFS shall use the following principles to set the rate for the second fiscal year:

(a) If the ICF-MR was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the ICF-MR began participation in the medical assistance program October second of that calendar year or later, the rate shall be determined under paragraph (A)(1) of this rule.

(b) If the ICF-MR was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the ICF-MR began participation in the medical assistance program October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83, and 5101:3-3-84 of the Administrative Code, except as follows:

(i) The inflation rate used to inflate the ICF-MR's desk-reviewed, actual, allowable per diem cost shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.

(ii) The ICF-MR's actual CPCMU is determined by dividing the ICF-MR's desk-reviewed, actual, allowable, per diem direct care costs from the partial calendar year cost report by the ICF-MR's actual case-mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the facility submits assessment information that qualifies for use in calculating a case-mix score(s), ODJFS shall use the median CPCMU for the ICF-MR as prescribed by paragraph (A)(1)(a)(i) of this rule.

(c) If the ICF-MR was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the ICF-MR began participation in the medical assistance program after the end of the calendar year, the rate shall be determined under paragraph (A)(1) of this rule.

(B) The ODJFS shall determine rates for an ICF-MR provider that changes provider agreements as set forth under 5101:3-3-84.5 of the Administrative Code within the existing building in the following manner:

(1) For the fiscal year in which change of provider agreement occurs, the new provider's initial rate shall be the same rate and method of calculation as for the previous provider, except as follows:

(a) The previous provider's rate must have been calculated using costs reported for a time period no older than costs from the calendar year preceding the current fiscal year. If the costs used to calculate the previous provider's rate do not relate to the calendar year preceding the current fiscal year or a three month period during the current fiscal year, the new provider's rate will be the peer group median rate calculated as follows:

(i) The direct care median rate will be calculated as determined under paragraph (A)(1)(a)(i) of this rule.

(ii) The protected median rate will be calculated as determined under paragraph (A)(1)(b)(i) of this rule.

(iii) The indirect median rate shall be the median indirect care cost reported for the calendar year preceding the fiscal year in which the rate will be paid for the applicable bed size peer group adjusted for inflation calculated in accordance with rule

5101:3-3-83 of the Administrative Code.

(iv) The capital median rate will be calculated as determined in accordance with rule 5101:3-3-84 of the Administrative Code.

(b) After the new provider files its three-month cost report under rule 5101:3-3-20 of the Administrative Code, the rate shall be determined under rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83, and 5101:3-3-84 of the Administrative Code using the costs reported on the three-month cost report, except as follows:

(i) The inflation rate used to inflate the new provider's desk-reviewed, actual, allowable per diem cost shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.

(ii) The new provider's actual CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the three-month cost report by the new provider's actual case-mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the facility submits assessment information that qualifies for use in calculating a case-mix score(s), ODJFS shall use the median CPCMU for the ICF-MR as prescribed by paragraph (A)(1)(a)(i) of this rule.

(iii) If the three-month actual cost report is filed after the ninety day due date and this report results in a lower rate, the rate shall be effective on the first day of the calendar quarter following one-hundred and eighty days after the end of the cost reporting period.

(iv) The rate calculated based upon the three-month cost report shall be effective starting the first day of the calendar quarter that begins more than ninety days after ODHS receives the cost report, except those reports under paragraph (B)(1)(b)(iii) of this rule.

(2) After the end of the fiscal year in which the change of provider agreement occurred, the rates for the second fiscal year and subsequent fiscal years shall be set using the new provider's cost report filed under rule 5101:3-3-20 of the Administrative Code for the full calendar year preceding the fiscal year in

which the rate will be paid and the provisions of rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83, and 5101:3-3-84 of the Administrative Code.

(a) If the new provider was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement occurred October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83, and 5101:3-3-84 of the Administrative Code except as follows:

(i) The cost basis shall not be any earlier than any portion of the calendar year preceding the second fiscal year. Otherwise, the rate in the second fiscal year will be calculated under paragraph (A)(1) of this rule.

(ii) The inflation rate used to inflate the new provider's desk reviewed, actual, allowable per diem cost shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.

(iii) The CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the partial calendar year ending cost report by the actual case mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the facility submits assessment information that qualifies for use in calculating a case-mix score(s), ODHS shall use the median CPCMU for the ICF-MR as prescribed by paragraph (A)(1)(a)(i) of this rule.

(b) If the new provider was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement ~~occured~~occurred October second of that calendar year or later or after the end of the calendar year, the rate shall be the same as the rate that was in effect at the end of the preceding fiscal year adjusted by the inflation rates and limited to ceilings as determined for the fiscal year under rules 5101:3-3-79, 5101:3-3-82, and 5101:3-3-83 of the Administrative Code. The rate shall be adjusted as provided in paragraphs (B)(1)(a) and (B)(1)(b) of this rule.

(c) If the new providers rate in the first fiscal year was the peer group median rate, the second fiscal year will also be the peer group median rate, as established for the second fiscal year, until a cost report for the new provider is received pursuant to paragraph (B)(2) of this rule.

(3) The provisions set forth under paragraph (B) of this rule do not apply to ICFs-MR which are new to the medical assistance program as defined under paragraph (A) of this rule, including ICFs-MR which receive a new license based upon the relocation of beds from existing ICFs-MR in operation immediately before the opening of the new facility. The rates for these facilities are calculated under paragraph (A) of this rule, as replacement facilities.

Effective: 09/12/2003

R.C. 119.032 review dates: 06/25/2003 and 09/12/2008

CERTIFIED ELECTRONICALLY

Certification

09/02/2003

Date

Promulgated Under: 119.03
Statutory Authority: RC 5111.02
Rule Amplifies: RC 5111.01, 5111.02, 5111.25.1, 5111.25.5
Prior Effective Dates: 7/1/93 (Emer.), 9/30/93, 6/30/94, (Emer.), 1/1/95, 12/17/98, 7/1/02

5101:3-3-89 **Intermediate care facilities for the mentally retarded (ICFs-MR): nonreimbursable costs.**

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism, except as specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable costs include but are not limited to:

(A) Fines or penalties paid under sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code.

(B) Disallowances made during the audit of the ICF-MR's cost report which are sanctioned through adjudication in accordance with Chapter 119. of the Revised Code.

(C) Costs which exceed prudent buyer tests of reasonableness which may be applied pursuant to the provisions of the "Provider Reimbursement Manual," ~~health care financing administration (HCFA)~~Centers for Medicare & Medicaid Services (CMS) publication 15-1 (effective 06/98), during the audit of the ICF-MR's cost report.

(D) The costs of ancillary services rendered to ICF-MR residents by providers who bill medicaid directly. Ancillary services include but are not limited to: physicians, legend drugs, radiology, laboratory, oxygen, and resident-specific medical equipment.

(E) Cost per case-mix units in excess of the applicable peer group ceiling for direct care cost set forth in rule 5101:3-3-79 of the Administrative Code.

(F) Expenses in excess of the applicable peer group ceiling for indirect care cost set forth in rule 5101:3-3-83 of the Administrative Code.

(G) Expenses in excess of the capital costs limitations set forth in rule 5101:3-3-84 of the Administrative Code.

(H) Expenses associated with lawsuits filed against the Ohio department of ~~human services~~job and family services (ODJFS) which are not upheld by the courts.

(I) Cost of meals sold to visitors or public (i.e., meals on wheels).

(J) Cost of supplies or services sold to non facility residents or public.

(K) Cost of operating a gift shop.

Effective: 09/12/2003

R.C. 119.032 review dates: 06/25/2003 and 09/12/2008

CERTIFIED ELECTRONICALLY

Certification

09/02/2003

Date

Promulgated Under:	119.03
Statutory Authority:	RC 5111.02
Rule Amplifies:	RC 5111.01, 5111.02, 5111.23, 5111.24, 5111.25, 5111.26, 5111.27, 5111.28, 5111.35 to 5111.62, 5111.99
Prior Effective Dates:	12/30/77, 8/3/79, 7/1/80, 1/1/84, 7/1/88 (Emer.), 9/25/88, 12/30/88 (Emer.), 3/31/89 (Emer.), 6/18/89, 10/1/89, 12/20/91, 9/30/93 (Emer.), 1/1/94, 12/17/98

TN #03-017 APPROVAL DATE _____
SUPERSEDES
TN #98-19 EFFECTIVE DATE 9/12/03